Person-centred healthcare research: A personal influence

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My interest in person-centred nursing grew when I was a learning disabilities nurse and realised that different people had different needs at different times. Consequently, standardised care was not care, just administration of people's lives, which disempowered both service users and carers. There is a need for intellectual clarity in person-centred healthcare, as the danger with such a global concept is that it becomes so generalised as to be meaningless (McCormack, B., Borg, M., Cardiff, S., Dewing, J., Jacobs,G., Janes, N., Karlsson, B., McCance, T., Mekki, T.E., Porock, D., van Lieshout, F., Wilson, V., 2015). This book (B. McCormack, van Dulmen, S., Eide, H., Skovdahl, K., Eide, T., 2017) supports researchers through decision-making in the research process to create person-centred knowledge.

The inclusion of person-centred research protocols that clearly illustrate key principles of person-centredness in research are useful for me as a researcher and supervisor. Engaging in respectful dialogue with others in the research, being aware of power in relationships and empowering participants, and interrogating our role in the research and making it transparent through reflexivity are complex concepts. They are difficult to realise in research practice and study design, but essential for producing research that incorporates the reality of service users and those who interact with them. As a researcher and educator, my focus is the experience of service users, wherever possible told by them. Ultimately, empowerment means service users need to become trained researchers, in order to make their shared experiences explicit. This was demonstrated in the chapter where people in recovery from schizophrenia interviewed other people with that diagnosis, giving a moving and insightful perspective on their lives (Davidson, 2017). The person-centred approach certainly presents challenges for researchers in terms of resources, time and access to service users. The investment of training service users to take part in research can be seen, in itself, as supportive of their personal growth, whilst also providing some resonant and authentic insights into the participants' worlds. It reflects the growth of research that recognises the role of service users in identifying their own needs and expectations (Hutchinson & Lovell, 2013), asserting their rights in influencing the discourse, and in the process rejecting the stigma associated with their diagnostic label.

The study protocols addressed a variety of different types of research question and methodology. These ranged from using critical creative enquiry to explore facilitated professional reflection on and for practice (Williams, 2017), to a mixed methods (surveys, qualitative case studies and analysis of public registry data) study into the implementation of public health legislation in Norway that was intended to reduce health inequalities by targeting families and children (Fosse, 2017). While embracing inclusivity within the research process, this research was able to gain an understanding of the perspective and needs of people for implementation at a systems level. This example of using a person-centred approach to address structural healthcare issues bridges the gap between small, person-

centred studies and large, group-based research. It serves as support to address issues that appear too large and multi-factorial for the more person-centred researcher.

A key message, for me, was the importance of considering ethics as the foundation of methodology, and including it as part of the study design, rather than as an afterthought. As healthcare researchers, we have a moral imperative of beneficence, which goes much deeper than a supportive interview manner and ensuring physical comfort. It incorporates sensitivity to the values and concerns of participants, and using them to inform the research design. Incorporating person-centredness within study design is complex both conceptually and practically, and I know this text would have been useful in my own research into health consultation experiences for people with learning disabilities (Chapman, 2014). These studies gave insight into how this can be done and should prove useful for students, supervisors and researchers who are new to this approach, or simply want to see how others do it.

The central tenet of this text, that healthcare practice and healthcare research should be person-centred, are justified using a moral philosophy perspective beginning with Kant's categorical imperative of treating people as an end in themselves and concluding with Rogers' understanding of the subjectivity of people in therapy and in research. The key point is that, despite an increase in claims of person-centred practice and policy, there is a gap between vision and reality. A key criticism of current research used to measure person-centredness is that it focuses on outcomes rather than on relationships. The contention of this text is that a different type of research is needed in order to access, comprehend and evaluate the person's experience of healthcare. Currently, the ethical and social demand for nurses and other healthcare professionals to act with care and compassion is high, but the lack of understanding of how to do this, and how to create systems and processes within which they can occur is limited. Person-centred care is both a means and goal for high quality care that incorporates ethical, individualised approaches, and this book gives us the tools both to interrogate claims that this exists and to enable service users to drive the research agenda.

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